Michigan Department of Community Health
Children's Special Health Care Services

INCOME REVIEW /PAYMENT AGREEMENT

Instructions for Completion (MSA-0738)

The Income Review/Payment Agreement (MSA-0738) is used to determine if a payment agreement is required of the family to receive coverage by the Children's Special Health Care Services (CSHCS) program.

General Instructions:

- Please **PRINT** clearly in ink.
- This form must be completed for the client.
- Do not write in the gray/shaded areas (official use only).
- Upon completion, keep ONE copy for your records.
- Mail **TWO** copies, and additional page(s)(if applicable) to:

  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  CSHCS DIVISION
  PO BOX 30734
  LANSING, MI 48909-8234

- If you need assistance, call **1-800-359-3722.**

SECTION 1 – Client Information (Adult Client or Minor Child) and Household Information

1. Enter the name of the client applying for CSHCS services.
2. Enter the Social Security Number of the client.
3. Enter the client's ID number (CSHCS or Medicaid) if client has one.
4. Enter the client's home address.
5. Enter the client's county of residence.
6. List other immediate family members in the household with CSHCS coverage (attach additional pages if needed).
7. Check all that apply to the client. **Note:** If you check any box in # 7, NO PAYMENT IS REQUIRED. Skip #8 and #9, and then go to #10 and enter the amount $0.00. Continue to Section 3.

SECTION 2 – Income Information (Note: Contact your local health department CSHCS office for help if you are unable to complete this section due to no Federal Tax Form, step-family exclusions, change in family size, loss of income, or other similar circumstance.)

8. Enter the total number of immediate family members (total number of exemptions on your Federal Tax Form from the previous year; see line 6 d. on the Federal 1040 or the 1040A, or line 5 of the Federal 1040EZ).
9. Enter the responsible party's income from the Federal Tax Form (line 22 of the Federal 1040, line 15 of the Federal 1040A, or line 4 of the Federal 1040EZ). If no Federal Tax Form is available, call 1-800-359-3722 for assistance. **Note:** Clients age 18 or older are legal adults; therefore, only their income is considered and not that of the family or guardian.
10. Enter the **Yearly Payment Agreement Amount** according to the enclosed Payment Agreement Guide (MSA-0738-B), even if the amount is $0.00.

SECTION 3 – Payment Agreement

Read each statement carefully. This is your Payment Agreement for services with the CSHCS program.

11. Signature of adult client or legally responsible party and date signed.
12. Print name of person signing #11.
13. Check box which identifies the person signing #11.

Payment Instructions

Monthly payment coupons will be mailed to the client's address. The monthly payment amount can be found on the Payment Agreement Guide (MSA-0738-B). Payments are to be made monthly using these coupons, or the full Yearly Payment Agreement Amount can be paid after receiving the coupons.

AUTHORITY: Title V of the Social Security Act
COMPLETION: Is Voluntary, but required if CSHCS program services are desired.

Michigan Department of Community Health
Children's Special Health Care Services

INCOME REVIEW / PAYMENT AGREEMENT

SECTION 1 – Client Information (Adult Client or Minor Child) and Household Information

1. Client Name (Last, First, Middle)	2. Social Security Number	3. Client ID Number	Suffix
4. Client's Home Address (Street, City, State, Zip)		5. County	Region

6. List other immediate family members in household with CSHCS coverage (attach additional pages if needed)

Name (Last, First, Middle)	Client ID Number	Birth Date

7. Does the Client have any of the following?

- Full Medicaid ..... ☐ Yes
- W.I.C. .....9-digit W.I.C. Family #_____..... ☐ Yes
- MIChild…..(Not mihealth) ..... ☐ Yes
- Does the Client live in a foster home or private placement agency?..... ☐ Yes
- Is the Client a ward of the county/state or is there a legal guardian?..... ☐ Yes
- Is the Client under age 18 and adopted with a pre-exisiting CSHCS eligible diagnosis? ..... ☐ Yes
- Is the Client deceased? (If Yes, date of death) _____ ..... ☐ Yes

IMPORTANT:

If you checked any box in #7, **NO PAYMENT IS REQUIRED.**

GO to Line # 10, enter $0.00, and continue completing the form. (*See instructions.)*

SECTION 2 – Income Information

8. Enter the total number of immediate family members claimed as exemptions on your **Federal Tax Form** from the previous year. .....

9. Enter the responsible party's income from the **Federal Tax Form** from the previous year. (Line 22 of the Federal 1040; Line 15 of the Federal 1040A; or Line 4 of the Federal 1040EZ) **$**

10. Enter the yearly amount of the required Payment Agreement according to the Payment Agreement Guide, (MSA-0738-B). ..... **$**

SECTION 3 – Payment Agreement

- I understand that if I did not check **ANY** box in #**7**, I agree to pay the State of Michigan the required amount on Line # **10** for Children's Special Health Care Services coverage for the period of one year.
- I agree to pay monthly or the full amount after receiving the payment notifications.
- If my circumstances change and I am unable to continue payments, I will contact CSHCS immediately for a possible adjustment to this agreement.
- I understand that when the Michigan Department of Community Health (MDCH) pays for services, any right to recover monies from a third person or public or private contractor (except for casualty cases transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan MDCH, Estate Recovery.
- I certify under the penalty of perjury that the information on this form is true, complete and accurate to the best of my knowledge. I understand that any misrepresentation of this information may result in the loss of CSHCS coverage.
- I authorize the State of Michigan to verify any information on this form.
- I understand that if the amount due to the State is not paid in full, it may result in non-renewal of my CSHCS coverage. If unpaid, my account may also be sent to the Michigan Department of Treasury for collection.

11. Signature of Adult Client or Legally Responsible Party	Date Signed	13. The person signing Box 11 is the:
12. Print Name Signed Above		☐ PARENT of Minor Client ☐ GUARDIAN of Client ☐ ADULT Client ☐ FOSTER PARENT of Client

Retain **PINK** copy. Mail the signed **WHITE** and **YELLOW** copies, with any additional page(s) to:

Michigan Department of Community Health
CSHCS Division
PO Box 30734
Lansing, MI 48909-8234